

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS650HOS1	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2010
NAME OF PROVIDER OR SUPPLIER MONTEVISTA HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 5900 WEST ROCHELLE AVE LAS VEGAS, NV 89103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 10/12/10 and finalized on 10/12/10, in accordance with Nevada Administrative Code, Chapter 449, Hospital.</p> <p>Complaint #NV00026631 was unsubstantiated.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>No regulatory deficiencies were identified.</p>	S 000			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE